(b) Divide the result from 2(ii) by the number of patient days.[17]

The property rate component will be set at the sum of the building and building equipment, moveable equipment, motor vehicle equipment and land rate subcomponents.

m. For any facility having an Initial Transaction[14] after July 13, 1978, and which has a subsequent transaction[15] on or after June 15, 1983 by the same party, a related party, or a different operator within ten years after the initial transaction, reimbursement is defined in subparagraphs (i) and (ii) below.

(i) During the ten years following an initial transaction prior to June 15, 1983, reimbursement will be the lesser of:

(a) costs as determined by subparagraph (f) (i) and (f) (ii),

(b) the Standard Per Diem, if the initial transaction occurred after May 6, 1981, but before June 15, 1983, or

(c) costs as determined by paragraphs (h) through (l) as the date of the lease, sale, or change of ownership which gave rise to the application of this paragraph.

(ii) During the ten years following an initial transaction after June 14, 1983, reimbursement will be the lesser of:

a) costs as determined by paragraphs (h) through (l) at the date of the initial transaction[14], or

(b) costs as determined by paragraphs (h) through (l) at the date of the subsequent transaction.[15]

n. For a facility having an addition, expansion, or renovation after June 14, 1983, reimbursement will be determined as follows:

(i) If the facility was being reimbursed under the provisions of paragraphs (a) through (f), reimbursement for additions, expansions and renovations will be subject to the limitations described in paragraphs (a) through (f).

(ii) If the facility was being reimbursed under the provisions of paragraphs (g) through (m), reimbursement will not be increased as the result of renovation unless all of the following conditions are satisfied:

- the renovation is mandated by state or federal law as implemented through policies and procedures of the

Georgia Department of Human Resources Standards and Licensure Unit

- the additional reimbursement is determined by a replacement cost appraisal as defined in paragraphs (b) through (e) (however, at the Department's discretion, for capital items not affecting the entire facility, multiple, competitive arm's length bids by contractors can be used instead of replacement cost appraisals).

Rev. 7/1/95

- the provider could not with reasonable diligence ascertain that the renovation would be required by the Georgia Department of Human Resources Standards and Licensure Unit. Reasonable diligence will include but is not limited to obtaining an inspection and its resulting report by the Architect of the Standards and Licensure Section specifically for the purpose of determining what repairs, renovations or other actions will be required of the facility to meet all applicable physical plant requirements, as well as all other inspections and deficiency reports on file at the Georgia Department of Human Resources Standards and Licensure Unit for that facility.

(iii) If the facility was being reimbursed under the provisions of paragraphs (g) through (m), reimbursement for additions and expansions will be subject to limitations described in paragraphs (h) through (l). If the addition or expansion does not add beds, there will be no additional reimbursement. If beds are added, the addition will be treated in a manner similar to a new facility to determine a separate property rate subcomponent for the addition.

Rev. 11/1/91

All property transactions described in Section 1002.5 must meet the criteria of Section 1002.4 in order to be allowed as a projection.

1002.6 Overall Limitations on Total Allowed Per Diem Billing Rate

In no case shall the Total Allowed Per Diem Billing Rate, whether determined under either Section 1002.2 or Section 1002.3, Nursing Home Manual, exceed the facility's customary charges to the general public for those services reimbursed by the Department.

1002.7 Payment in Full for Covered Services

The facility must accept as payment in full for covered services the amount determined in accordance with Section 1002, Nursing Home Manual.

1002.8 Recapture of Depreciation[22]

A) Definition

When an asset for which Medicaid reimbursement for depreciation has been received is sold at a gain, such reimbursement will be subject to recapture. Gain is determined to be the difference between net book value (historical cost less accumulated straight line depreciation recognized for Medicaid reimbursement purposes) and the selling price. Gain is calculated in the aggregate without adjustment or offset for the gain attributed to return on equity, inflationary increases in the market value of the remaining assets, or for increases in value due to supply and demand for the assets in the marketplace. Recapture of depreciation will occur based on the procedure described below:

1) The provider (seller) should notify the Department of the proposed sale of a facility as soon as a commitment is made between the seller and the buyer. Notification regarding this transaction must be submitted to the Department by use of the Property Transaction Projection Information Package, supplied by the Department (see Section 1002.4(b) of this manual). Notification and complete details of the proposed sale should be submitted to the Department immediately upon entering into the contract of sale (refer to Section 1002.4(b)) of this manual. Failure of the provider (seller) to notify the Department of the proposed sale shall not preclude the Department from recapturing depreciation on the sale.

Rev. 4/1/91

2) The provider must repay the Department for reimbursement previously received for depreciation which the provider recaptures by sale of the asset(s). The proper amount as calculated in Subsection 3) and 4) below is due and payable to the Department upon consummation of a sale and is the obligation of the seller. If the seller defaults, recoupment will be made from the purchaser. The purchaser will be notified of the default, at which time the purchaser should remit payment, or the amount due will be offset against future payments due the provider.

Rev. 7/1/91

3) The phasing out of depreciation recapture will occur based on the following conditions:

a) Full recapture is due if the facility or other depreciable asset was reimbursed for depreciation less than 5 years.

Rev. 7/1/91
Rev. 11/1/91

b) If the facility or other depreciable asset is reimbursed for depreciation over 5 years but less than 15 years, the amount of recapture will be reduced by .83334% for each month in excess of 60 months that the asset was reimbursed for depreciation by the Department.

Rev. 7/1/91

c) If the facility or other depreciable asset is reimbursed for depreciation more than 15 years, then no recapture of depreciation is due.

4) If the facility or other depreciable asset is leased after depreciation has been reimbursed, recapture rules will apply for the dollar amount and number of months of actual depreciation reimbursed by the Department prior to the leasing agreement.

5) All providers that withdraw from the Medicaid program will be required to sign a contract provided by the Department creating an equitable lien on the nursing home assets which are subject to repayment of depreciation recapture to the Department. The amount of this lien is the depreciation recapture amount due upon the sale of the facility.

6) Facilities which are reimbursed for capital costs under the Dodge Index Formula prior to the sale are excluded from these recapture provisions.

B. Failure to Comply

All providers must comply with the provisions described in Sections 1002.8(A)(I) or 1002.8(A)(5) within 30 days of the commitment to sell or withdraw from the program. Providers who fail to notify the Department (Nursing Home Reimbursement Section) of a proposed sale as soon as a commitment is made between the buyer and seller or who fail to sign a contract upon withdrawal from the Medicaid program, will have per diem payments withheld until the above requirements are met. The Department may also pursue any other remedies available under law.

Falsification of reports will result in reduction of payment, a minimum thirty-day denial of payment for newly admitted Medicaid residents, suspension or termination from the program or criminal prosecution, whichever is appropriate as determined by the Department.

1003. Additional Care Services

For dates of service on or after July 1, 1986, the Department will reimburse nursing facility providers to provide for additional care services to nursing facility recipients. These provisions will apply in addition to all others in this chapter and will supersede those which are in direct conflict only to the extent that they are not capable of simultaneous application.

1003.1 Increase in the Required Nursing Hours

Rev. 10/1/90

The minimum required number of nursing hours per patient day for all Level I and Level II nursing facilities is 2.50 actual working hours effective July 1, 1986. The nursing facility's actual nursing working hours originally were calculated from the 1985 cost report adjusting the total paid hours by a standard percentage of 6.0 for vacation, holiday and sick time. The projected cost of increasing actual working hours to 2.50 hours was subject to a maximum increase for any facility of $2.77 per patient day. Prior to April 1988, a facility could exceed the Routine Services Standard Per Diem as a result of increased staffing; however, the incentive was calculated at the 75th percentile. Effective April 1, 1988, the projected costs are included in the 1987 cost report. Therefore, the Standard Per Diem for Routine Services can no longer be exceeded. The 2.50 actual working hours requirement applies to all Level I and Level II facilities.

1003.2 Increase in Routine Services Percentile

Rev. 7/1/99

The Routine Services percentile for all nursing facilities is the 90th percentile for the purpose of recognizing cost and the 90th percentile for calculating the incentive. Incentives calculated on April 1, 1987, July 1, 1988, August 1, 1988, April 1, 1989 and 1990 and July 1, 1991, 1992, 1993, 1994, 1995, August 16, 1996, October 1, 1998 and July 1, 1999 will not be adjusted except as a result of audits of a cost report or other allowable cost changes.

1003.3 Addition of Intensity Allowance

Rev. 7/1/99

A four percent intensity allowance will be added to the current growth allowance rate for all cost centers except Property and Related for all Level I nursing facilities.

Rev. 7/1/99

A three (3) percent intensity allowance will be added to the current growth allowance rate for all cost centers except Property and Related for Level II nursing facilities, which maintain an average Medicaid skilled care occupancy level of 15 percent or greater during a six-month reporting period described in 1003.4 below. Level II nursing facilities which maintain an average Medicaid skilled care occupancy level of 25 percent or greater during a six-month reporting period as described in 1003.4 below will receive a four (4) percent intensity allowance. A five

Rev. 7/1/99

(5) percent intensity allowance will be given to freestanding Level II facilities which maintain an average Medicaid skilled care occupancy level from 50% to 60% for a six-month reporting period. These allowances are to cover the cost of oxygen, catheters, parenteral supplies and other special supplies associated with heavy care patients.

Rev. 4/1/99

The intensity allowance is a recognition of an increasingly severe patient case mix and the technological demands associated with the care therapies for that case mix. The January 1 to June 30 census information report described in 1003.4 below will be used to determine the appropriate intensity allowance for the period October 1 to March 31. The July 1 to December 31 census information report described in 1003.4 below will be used to determine the appropriate intensity allowance for the period April 1 to September 30.

1003.4 Medicaid Skilled Care Occupancy Report

All census information must be submitted using the Occupancy And Rate Data form, no later than January 31 and July 31 for the six-month periods ending December 31 and June 30, respectively, of each year. For the six-month census information report beginning January 1, 1989, to June 30, 1989, Medicaid recipients who also are recipients of Medicare and have payments made in their behalf by Medicare must be included in the appropriate Medicaid occupancy column on Schedule A.

1003.5 Failure to Comply

Rev. 10/1/90

a) Effective July 1, 1986, the minimum standard for nursing hours is 2.50. All Level I and Level II facilities (including hospital-based) must comply with the 2.50 nursing hours standard. Any facility not meeting the 2.50 requirement, will lose its entire projection under subsection 1003.1 for the applicable period, as determined by the Department.

b) Facilities found not in compliance with the 2.50 nursing hours will be cited for being out of compliance with a condition of participation. This will lead to loss of projection for the applicable period, imposition of a civil monetary penalty, denial of reimbursement for newly admitted patients, or suspension or termination whichever is appropriate as determined by the Department.

Rev. 4/1/91

c) Level II facilities (including hospital-based) which fail to maintain an average skilled patient occupancy level of 15 or 25 percent (as described in 1003.3) during a reporting period and freestanding Level II facilities which fail to maintain an average skilled patient occupancy level of from 50 to 60 percent for the reporting period will have the intensity allowance(s) reduced as appropriate for the applicable six-month period(s), beginning on October 1 or April 1, as indicated in 1003.3 above.

d) Facilities submitting late or no reports (as required in Section 1003.4) may be assessed $10 per day of lateness. A facility which submits a report more than 30 days after the deadline will have its rate reduced by the amount of its intensity allowance. Falsification of reports will result in reduction of payment, a minimum thirty-day denial of payment for newly admitted Medicaid residents, suspension or termination from the program or criminal prosecution, whichever is appropriate as determined by the Department.

1004. Voluntary Salary Adjustment

Rev. 11/1/89 A) Definition

Reimbursement will be available for non-State facilities to increase salaries for non-administrative personnel. This includes RNs, LPNs, Aides, Social/Activity Directors, Dietary, Laundry and Housekeeping Employees, but does not include Directors of Nursing. These funds are designed to permit facilities to maintain required staffing levels, attract qualified staff and provide quality care.

Participation in the salary adjustment projection program is voluntary.

The basis for the projection is the difference between salaries paid on September 30, 1989, and salaries paid on October 1, 1989, and thereafter. This projection cannot be used to defray the costs associated with salary increases granted prior to October 1, 1989, nor shall the projection be added to pre-October 1, 1989 date of service per diems.

The total increase for all eligible employees should include annual salaries and the fringe benefits which are attributable only to the salary increases, such as payroll taxes and worker's compensation. The difference between the increased salaries and the previous salaries will be divided by the patient days on the 1988 and 1989 billing rate calculation statements to determine the total dollar amount to be added to the per diem rate.

The increase in the per diem rate resulting from the increase in salaries will be treated as an add-on (subject to a $1.87 maximum) to the established total per diem rate effective with payments made after November 1, 1989 for October 1, 1989 and after dates of service. The projection will not be subject to the cost center ceilings, but will in no case exceed $1.87 per diem.

The Salary Increases Cost Package, supplied by the Department, must be completed by all participating nursing facilities listing the totals for each job title. The difference in each job class should be totaled and divided by 1988 and 1989 patient days to determine the total per diem increase. The Department will review and determine acceptability of all projection requests.

Rev. 11/1/89

Each facility is required to keep all records concerning pay raises for audit purposes. The State Department of Audits will be instructed to review your payroll records regarding the submitted projection. Should the money allocated to your facility for these salary increases not be spent, a refund will be required.

Existing facilities' projections for salary increases must be received by the Department prior to September 30, 1989, in order to process the rate increase effective with the October prebills paid in November, 1989.

Incomplete requests will be returned to the submitting provider. Any projection request which is received and accepted after September 30, 1989, or which is not complete until September 30, 1989, will be processed with November prebills paid in December 1989. Projection requests received after October 31, 1989, will not be considered.

New facilities not having the appropriate cost report information must complete one month of service with payroll data subsequent to the month of enrollment. A salary adjustment then can be effective the first day of the first month following the first complete month of service.

B) Failure to Comply

Falsification of reports will result in reduction of payment, a minimum thirty-day denial of payment for newly admitted Medicaid residents, suspension or termination from the program, or criminal prosecution, whichever is appropriate as determined by the Department.

1005. Omnibus Budget Reconciliation Act (OBRA)

Rev. 10/1/90

The OBRA 1987 and 1990 law requires significant changes in nursing facility operations, administration, nurse aide training, hiring and staffing practices, resident care planning, and the overall provision of resident care services. The following changes in payment methodology are made to account for nursing facilities costs to comply with OBRA requirements.

Rev. 7/1/92

A) Reimbursement Implementations

1) Adjustments for Nurse Aide Training

The Department adjusted per diem rates by $0.50 for dates of service July 1, 1991 to June 30, 1992 to reimburse the costs associated with replacement wages and overtime for nurse aide training and testing. This adjustment did not apply to ICF/MR facilities. For dates of service July 1, 1992, and after there will be no adjustment for replacement wages and overtime for nurse aide training and testing because the costs are already included in the 1991 cost report.

Rev. 7/1/92

2) Adjustments by Facility Type or Bed Size

The Department makes the adjustments described below:

a) All nursing facilities classified as Level III as of July 1, 1992, will receive a per diem rate add-on of $.36.

b) All nursing facilities not included in a) above which have more than 120 beds as of July 1, 1992, will receive a per diem rate add-on of $.28.

c) All nursing facilities not included in a) and b) above will receive a per diem rate add-on of $.24.

Rev. 7/1/93

d) For dates of service July 1, 1993, and after, there will be no adjustment for OBRA requirements because the costs are already included in the 1992 cost report. The OBRA adjustments to reimbursement rates do not apply to intermediate care facilities for the mentally retarded.

3) Adjustment for Purchase of Computers

Rev. 8/16/96

All non-State facilities will receive an $.08 per diem add-on for purchasing computers to encode the minimum Data Set (MDS) in machine-readable format for electronic transmission to the State and for other purposes. The $.08 per diem add-on will be eliminated with dates of service August 16, 1996, and after.

1006. Freestanding Nursing Facility Classification and Reimbursement Based On Medicaid Skilled Care Occupancy

Rev. 4/1/91

1006.1 a) If a Level I facility maintains an average Medicaid skilled care occupancy level of 85% or more for a reporting period, the facility's reimbursement rate will not be adjusted for level of care.

b) If a Level I facility's average Medicaid skilled care occupancy level is from 75% to 85% for a reporting period, the facility's rate for a skilled care patient will not change, but the rate for an intermediate care patient will include 95% of the facility's Routine Services and Dietary allowed per diems, plus 100% of the facility's allowed per diems for Laundry and Housekeeping and Administrative and General, plus property and the appropriate growth allowance.

c) If a Level I facility's average Medicaid skilled care occupancy level is from 60% to 75% for a reporting period, the rate for a skilled care patient will not change, but the rate for an intermediate care patient will include 90% of the facility's Routine Services and Dietary allowed per diems, plus 100% of the facility's allowed per diems for Laundry and Housekeeping and

Rev. 4/1/91

Administrative and General, plus property and the appropriate growth allowance.

d) If a Level I facility's average Medicaid skilled care occupancy level is less than 60% for a reporting period, the facility will be reclassified as a Level II nursing facility and the facility's rate will be calculated using the standard per diems appropriate for the Level II classification, plus property and the appropriate growth allowance.

Rev. 7/1/92

e) If a Level II facility maintains an average Medicaid skilled care occupancy level of 60% or more for a reporting period, the facility will be reclassified as a Level I nursing facility. The facility's rate using the current cost report and Level I standards.

Rev. 4/1/91

f) If a Level I facility's combined Routine Services and Dietary allowed per diems are less than the combined Level II Routine Services and Dietary standard per diems, there will not be an adjustment as described in items (b) and (c) above.

g) The initial "reporting period" will be July through December 1990, and will be every six (6) months thereafter. The reports will be due to the Department thirty-one (31) days after each reporting period ends. Changes in classification and rates as a result of six-month occupancy reports will be effective for the following quarter, i.e., April or October.

Rev. 4/1/91 1006.2 All new freestanding nursing facilities initially will be classified as Level II, Level III or ICF/MR, as appropriate. If a new facility meets the requirements for classification as Level I (as described in 1006.1), the facility must submit monthly Medicaid skilled care occupancy reports and any other documentation to the Department to justify reclassification. For reimbursement purposes, a new facility will be reclassified based on the first monthly occupancy report which documents that requirements for Level I classification have been met. The monthly occupancy reports must be received by the Department each month until the first January to June or July to December report is due as required by Subsection 1003.4. In order to remain in the Level I classification, the monthly or other period occupancy reports received must continue to justify Level I status; otherwise, reclassification to Level II will occur immediately. This information is subject to review by the Department or its agents.

1007. Rev. 2/1/91 Effective with payment dates of February 1, 1991 and after, the maximum allowable payment for Medicare nursing facility coinsurance (crossover) claims will be the nursing facility's Medicaid specific per diem rate in effect for the dates of service of the crossover claims. The crossover claims will not be subsequently adjusted due to subsequent per diem rate adjustments. This section is also included in Chapter 1100 of the Manual.